Valley Health:
Caring for you and the world around you

January 2011
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Passage of the federal Patient Protection and Affordable Care Act of 2010 (PPACA), along with adoption of California’s Section 1115 Medi-Cal Waiver, has ushered in a new era for health care in the County of Santa Clara and, indeed, in the entire state and nation. These new policies are intended to extend health coverage and access to care to millions of Californians, redesign the delivery system, align financial incentives, and improve quality. At the same time, the new law sets forth a vision for enhancing the health of the population through many interconnected, prevention-related activities.

Successfully transitioning to meet the demands of the new health care environment will not be easy. Whether the potential of these policies will be realized depends on whether health care organizations can rise to the challenge. The Santa Clara Valley Health and Hospital System (SCVHHS) has significant assets and all the essential components to thrive in the post-reform world. It has a high-quality medical system, a full spectrum of services, including mental health and substance abuse programs, as well as a managed care plan and a public health department.

Despite SCVHHS’s many strengths, however, its components are not aligned, united under a common vision or purpose, nor integrated. Only a fully integrated system dedicated to improving the health of patients and the community will secure the system’s future and comply with the new policy environment mandated by PPACA and the new California Waiver. To achieve this integration, SCVHHS will need to overcome considerable barriers. These barriers are not only operational and financial; they are systemic. Consequently, success will require system-wide solutions.

Alvarez & Marsal (A&M) was retained by the County of Santa Clara on March 8, 2010, to help SCVHHS address a number of significant operational issues. Shortly after, PPACA was enacted, and the Section 1115 Waiver adopted—adding an entirely new set of challenges for SCVHHS. Although solving the operational issues remains critically important, their resolution alone will not be enough to prepare the system for a vastly different future. It became clear immediately that the current structure and direction of SCVHHS were inconsistent with the new environment. Therefore, A&M undertook a rapid strategic planning process with the SCVHHS senior leadership team. We all understood that a new vision—a “North Star”—was necessary for guiding the system’s response to the changes ahead. This Strategic Vision Framework is the result of that effort. It provides a policy structure for developing the integrated health system critical for success in the post-reform world.

This document, however, is only the first step in system transformation. It will be followed by an in-depth implementation plan, detailing timelines and action steps. To begin with, though, this framework must be the guide for all future decisions concerning SCVHHS—particularly budgetary decisions. Funding and program decisions cannot be made in isolation or devoid of any policy context. The implementation plan must be executed, and all subsequent decisions made, in the context of their relevance to overall system needs. All activities must be aligned with the goals of the strategic vision, and be weighed in the context of how they will advance the organization’s future direction.

SCVHHS stands at a strategic crossroads. The opportunity is unprecedented, and unlikely to come around again, so we don’t believe that we will have a second chance to get this right. We must create a new delivery system now, one that lives up to the promise of reform. To do so will require a unified effort, fueled by a comprehensively accepted sense of purpose and an abiding understanding of what is at stake here—the future of SCVHHS and the health of the people who depend on it.
On March 8, 2010, the County of Santa Clara retained Alvarez & Marsal (A&M) to assist the Santa Clara County Valley Health and Hospital System (SCVHHS) in addressing a number of significant operational challenges, and in preparing the system for a range of changes resulting from state and federal actions. An essential element of this assistance was developing a new strategic vision for the system. The effort was driven also by the obligation to comply with the Board of Supervisors (BOS) mandate for submitting a strategic plan to its Health and Hospital Committee.

Although A&M convened the leadership group of SCVHHS and supported this process, this is not the A&M plan for the system’s future. This document is the collective view of SCVHHS leadership. It represents their assessment of the challenges they face, the opportunities for dramatic program change and performance improvement, and the unanimous opinion that although significant difficulties lie ahead for SCVHHS, it has embedded in its people the skills, training, philosophy, and discipline for rapid system transformation.

Our confidence is tempered, however, by the acknowledgement that the manner in which the system has grown and been sustained—the funding, policy environment, and performance expectations—has changed permanently. New laws, mandates, and payment methods, along with the pressing imperative for transparency, accountability, and high performance, are the new normal. Providing good care is not enough anymore. If the elements of this system are not redirected and organized to be more consistent with the system’s resources, training, and intuitive grasp of what constitutes “good health,” the group of programs SCVHHS provides will erode to the point that they will be unrecognizable. This can be avoided. The good fortune of the County of Santa Clara is that it has the basic elements, traditions, competence, and size to change its direction, or “North Star.” The question is whether it has the will to do so.

The strategic planning group understood at once the enormous responsibility and opportunity that the current environment presents. This required setting aside immediately any conventional plans for the system. We did not discuss how to “tweak around the
edges” in order to increase the hospital census or modify a service line, for example. The environment and our circumstances call for much more. Passage of federal health care reform through the Patient Protection and Affordable Care Act of 2010 (PPACA)—and the state policy mandates contained in the new California Section 1115 Waiver—require examining the system’s overall direction, from structure to financial management and operations. Ultimately, this strategic plan must set the course for creating a high-quality, efficient, and community-oriented organization. The hospital, as valuable as it is as a community resource, can no longer be the center of the program universe. The new focal point is integrated community health.

We can view this change in another and very topical way. Throughout this process, we noted that it is time for the County of Santa Clara to “rebalance” its “portfolio.” New investments follow new realities. Community Health, for instance, will require a substantial change in how it is organized and funded in order to create a strong foundation, while Public Health, Mental Health, Alcohol and Drug Services, Ambulatory Care, and Managed Care programming will be the new system’s cornerstones.

Chart 1. The eight attributes of a fully integrated health care system

- Puts the patient and community first (No, really!)
- Tolerates no strategic confusion
- Teams well
- Executes meticulously
- Works the middle of the organization
- Communicates always and successfully
- Maintains a self-enforcing culture
- Masters the “interstitial space,” or the connective tissue of the organization

“"We must think and organize far beyond the idea of how to better manage the care and treatment of individuals. We must think, act, and invest in terms of improving the health of the entire population we serve.”

- Dan Peddycord, RN, Director, Department of Public Health, SCVHHS

Our discussion of this shift was accompanied by another frank acknowledgement of the current environment. Our management capability, decision-making, service ethic, and even our definition of time must also adjust to the new reality. We have listed here the eight attributes of a well-managed, well-integrated, and fully aligned health care system (see Chart 1). These attributes are featured prominently so that a basic reform concept is clear to all who have an interest in this report. It is not enough to think about these things; we must be prepared to do them now and do them well.

Our planning process was helped immeasurably by a coincidence. Shortly before we began our work, the health system executives, among other county leaders, attended a “Rapid Transformation” training session scheduled by the County Executive and conducted by Stanford University. The training and its themes of time, focus, inspiration, and North Star planning were a great spur to our own strategic planning exercise, providing our work group with a solid foundation and common vocabulary. Several of the concepts taught at Stanford are woven throughout this report.

For SCVHHS, the complexity and breadth of the forces that are converging on the system—external and internal—are unprecedented. The luxury of time to confront these conditions does not exist. Fortunately, the need to change the direction of the organization is well understood by system leaders, and the commitment to doing so is unanimous. Note the unusual step of each program leader and executive in signing this report as it is transmitted to the Board of Supervisors and the County Executive. This signal of commitment and purpose must be understood and reinforced constantly throughout the system.

As planning converts to action, this Strategic Vision Framework will serve as a charter for aligning perspectives, accelerating the change process, and achieving the goal: a stronger, more integrated, more resilient organization that truly puts its patients, and the community, first.
The planning process

Once responsibility was assumed for developing and presenting a strategic framework for SCVHHS, A&M established a council of executive leaders to recommend a course of action. Led by Mark Finucane of A&M, the council and A&M committed to completing this task within 60–75 days.

**Process steps and key activities**

- Review all of the health agendas and strategic business plans (21) currently being prepared, updated, and distributed to the Santa Clara BOS, County Executive, and the Deputy County Executive/Acting Director of SCVHHS.
- Understand the implications of the most recent state and federal health policy developments, including federal health care reform, the California Waiver plans, state budget decisions, coordinated care principles, and local leadership changes.
- Consider the current and future financial circumstances confronting the County of Santa Clara government.
- Include in this planning effort the development of a unified managed care strategy for Valley Health Plan (VHP) and Santa Clara Family Health Plan (SCFHP), and align results with the goals and framework of the overall SCVHHS strategic plan.
- Develop a final strategy report (20–25 pages, with attachments) for submission to the County Executive Officer, the Deputy County Executive, Health and Hospital Committee, and the full BOS for review and approval.
- Ensure that the final report incorporates the current operational plans and restructuring being implemented at the Santa Clara Valley Medical Center (SCVMC), and that coordination and integration of those activities proceed unencumbered by this or any other process.

**Planning participants**

**SCVHHS Strategic Committee**

- **Sylvia Gallegos**, Deputy County Executive/Acting Director, SCVHHS
- **Trudy Johnson, MA, RN, NEA-BC**, Chief Nursing Officer and Interim Executive Director, Hospital and Ancillary Services, SCVMC
- **Nancy Kaatz**, Chief Financial Officer, SCVHHS
- **Dolly Goel, MD**, Medical Director, SCVMC
- **Alfonso F. Banuelos, Jr., MD**, Chief Medical Officer, SCVMC
- **Nancy Pena, PhD**, Director, Mental Health Department, SCVHHS
- **Daniel Peddycord, RN, MPA/HA**, Director, Department of Public Health, SCVHHS
- **Robert Garner**, Director, Department of Alcohol and Drug Services, SCVHHS
- **Paul Estess, RN, MPH**, Acting Executive Director, Ambulatory and Managed Care, SCVMC
- **Robin Roche**, Former Executive Director, Ambulatory and Managed Care, SCVMC
- **Michael Lipman**, Acting Director, Planning, Contracting and Business Development, SCVHHS
- **Amy Carta**, Assistant Director, SCVHHS

**Unified Managed Care Committee**

- **Elizabeth Darrow**, Chief Executive Officer, SCFHP
- **David Cameron**, Chief Financial Officer, SCFHP
- **Greg Price**, Chief Executive Officer, VHP
- **Dolly Goel, MD**, Medical Director, SCVMC
- **Larry Bonham, MD**, Medical Director of Clinical Services, VHP
- **Pat Cox, RN**, Director of Clinical Services, VHP
- **Nancy Kaatz**, Chief Financial Officer, SCVHHS
- **Robin Roche**, Former Director, Ambulatory and Managed Care, SCVMC
• **Michael Lipman**, Acting Director, Planning, Contracting and Business Development, SCVHHS

• **Amy Carta**, Assistant Director, SCVHHS

**A&M Members**

• Mark Finucane

• Barbara Masters

• Jim McLarty

• Erica Lister

**Additional activities**

In addition to the weekly meetings and the work associated with them, a few other essential activities were undertaken by A&M to augment committee work:

• We met regularly with the County Executive Officer and the Interim Agency Director so that the direction of the planning effort was consistent with the strategic direction of the general government departments. Particular attention was given also to the need to educate and thus enlist the other operating departments in their role in developing a healthy and safe environment for all of the citizens of the County of Santa Clara.

• We conducted individual interviews with 20 physicians across primary and specialty areas—and reported the findings to the planning group.

**Background**

**SCVHHS: many organizations, multiple missions**

SCVHHS offers a range of health care services, programs, and policy leadership to restore, maintain, and improve the health of the residents of the County of Santa Clara. These services are provided through many entities, including:

• **Santa Clara Valley Medical Center**, the county’s largest hospital and public safety net. The 574-bed hospital and nine clinics provide high-quality, specialized care for ambulatory care, emergency trauma, burns, and rehabilitation services.

• **Santa Clara Public Health Department (PHD)**, with the mission of protecting the health of the surrounding community and preventing the spread of disease and injury. Governed by the California Health and Safety Code, the PHD is made up of seven divisions designed to reflect the needs and characteristics of county residents.

• **Santa Clara Mental Health Department (MHD)**, providing over 22,000 residents with access to county-operated and contracted mental health services each year. Federal, state, and local resources are used to fund MHD, and services are provided through three divisions.

• **Children’s Shelter and Custody Health Service (CSCHS)**, providing comprehensive medical, dental, mental health, and pharmacy services to the inmates and detainees of the county’s correctional system.

• **Department of Alcohol & Drug Services (DADS)**, the largest provider of substance abuse treatment in the County of Santa Clara and one of the largest in California. Through its network of over 20 county and community-based organizations, DADS provides care to over 9,000 residents.

• **Community Health Services (CHS)**, devoted to promoting the health and well-being of children and families by providing access to public health services and quality health insurance.

• **Valley Health Plan**, a state-licensed health maintenance organization owned and operated by the County of Santa Clara, offering commercial insurance to public employees since 1985. VHP currently has 13,600 lives enrolled from the County of Santa Clara, Valley Transportation Authority, In-Home Support Service Workers, and several small groups. VHP also manages care for approximately 65,000 individuals enrolled in various government-subsidized health care programs, including 1) SCFHP members who are enrolled in public programs such as Medi-Cal, Healthy Kids, Healthy Families, and Healthy Workers and who use VMC and its network and 2) Valley Health enrollees, who include a portion of the county-uninsured program and the federally subsidized 1115 Waiver patients.
**Internal environment: out of alignment**

In reviewing the current planning activities for SCVHHS, we found that multiple plans exist that have been developed primarily in response to laws, regulatory requirements, and requests from the BOS. These multiple plans and goals have created policy contradictions and a damaging lack of system alignment.

Another contributor to the complexity is the system’s current managed care structure. SCVHHS interacts with two managed care plans: Valley Health Plan, operated by the county, and Santa Clara Family Health Plan, operated by a public governing board. The current configuration has resulted in redundant and inefficient processes, network confusion, and at times, competing priorities.

**External environment: catalysts for change**

Addressing these internal challenges is made all the more urgent by a host of external pressures. Over the next several years, California’s health care system faces an era of unparalleled change. The catalysts are several key policy initiatives, headlined by PPACA, the recently agreed-to new Section 1115 Medi-Cal Waiver, and the national mental health parity law. These new policy drivers have the potential to address many of the contradictions and inconsistent incentives that have arisen as a result of layers of past waivers, policies, and legislation. Transforming the current patchwork of siloed providers, reimbursement mechanisms, and programs into an integrated health system will require significant changes in the delivery system. At the same time that SCVHHS must prepare for these reforms, chronic budget challenges at the state and local levels have resulted in reduced support for the safety net the system provides, while demand for services has gone up as the recession has grown.

Taken together, the policy initiatives will extend health insurance coverage to millions of Californians, spur expansion of the health workforce, redesign the health delivery system, and prioritize prevention. Importantly, the new law and the California Waiver will provide incentives for systems to create medical homes, integrate primary care and mental health services, and coordinate care, particularly for the chronically ill. Potential new resources under the Waiver for public safety net systems, for example, are explicitly tied to meeting certain milestones related to implementing system reforms.

PPACA will expand Medi-Cal coverage by as much as 25 percent, or about 1.8 million individuals in California, with the federal government paying a much higher proportion of the costs for the expanded population. In the County of Santa Clara, that could mean an additional 35,000 to 45,000 residents having Medi-Cal coverage. Also, 4.5 million Californians will gain access to health insurance through a new health insurance exchange—an estimated 2.4 million of whom will receive some type of subsidy. Even when PPACA is fully implemented, however, a segment of the population will still be uninsured, and SCVHHS will likely continue to see a large portion of this remaining population.

In anticipation of these changes, to be implemented over the next several years, the health care marketplace—fluid in even the best of times—is experiencing a high level of anxiety and uncertainty. Physician groups, health plans, and delivery systems are forming new alliances as they seek to position themselves for what lies ahead. For example, in setting a course of action, industry executives and clinical leaders are trying to determine:

- How the health care system will absorb millions of newly insured people
- Whether the Medicaid expansion will mean more patients for the safety net, more competition, or both
- What the implications of the new health insurance exchange are for public health plans and safety net providers
- How the remaining uninsured will receive needed health care services
- Which providers or plans to partner or align with to create integrated systems
- What the implications of the recent elections are for the planning process related to PPACA

Although the major provisions of PPACA don’t take effect until 2014, the Waiver is immediate. With continuation of the Health Care Coverage Initiative, and the enrollment of the Seniors/Persons with Disabilities population in managed care, the Waiver seeks to be a “bridge to reform.” It is providing the means to redesign the system, with specific goals and milestones that must be achieved, beginning in 2011.

The combination of these events leads to one inescapable conclusion: the status quo will not suffice. SCVHHS must be prepared unequivocally to change its direction, operations, and management approach, and it must begin immediately.
Opportunities to improve the delivery system

At the same time that A&M had been asked to assist in developing a strategic vision for the system, we were assigned a number of initiatives that were critical to the current system’s performance. The work, primarily related to the delivery system, became a valuable educational tool in preparing the strategic plan. This “punch list” of assignments described below made clear the need for an entire redirection of the system and the manner in which it is managed. Fixing each of these areas is important, but unless they are viewed as enablers or accelerants of system change, they will be a list of unconnected “system dysfunctions” that have turned bad enough to cost either significant dollars or human suffering, or both.

Consequently, we looked at them differently. These are all policy-driven change opportunities associated with three main areas of focus for the delivery system: operations/finance, managed care, and physician alignment. Improving these areas is essential to the system’s strategic repositioning on the post-reform horizon, but none of them is determinative. Many of the participants in our planning process were involved in creating these policy-driven changes. This provided us with an opportunity to note the effects each had on our broader change initiative.

Creating policy-driven change in operations and finance

- **Expanding panel management.** The SCVHHS safety net has been closed to new patients seeking assignment to a primary care physician. The purpose of the panel management project is to establish new policies and support structures, in an effort to improve primary care access and actively manage physician panels, thus decreasing overutilization of the Emergency Department, Urgent Care, and Specialty Departments.

- **Reducing one-day stays.** SCVMC has experienced avoidable hospitalizations due to a lack of access to other parts of the SCVMC system—resulting in a one-day-stay
rate far in excess of industry standards. This initiative aims to determine the root causes and financial impact of excessive one-day stays as well as improve overall medical practice patterns to prevent unnecessary hospitalizations.

- **Re-engineering rollout of the electronic medical record (EMR).** The EMR rollout has been fraught with operational challenges and functionality issues, contributing to a decline in patient throughput in the clinics. This project aims to assist in creating, monitoring, and implementing a plan to improve EMR workflows, functionality, and overall user experience.

- **Improving performance reporting.** In an effort to improve reporting to SCVHHS and SCVMC senior management, the performance reporting initiative is designed to ensure the timely flow of information to management and executive leadership for informed decision-making.

- **Assessing federally qualified health care (FQHC).** SCVHHS provides ambulatory care in a combination of FQHC and fee-for-service settings. This project assesses the fiscal impact of the current structure and recommends ways in which to capitalize on the current market as well as adjust to anticipated changes in reimbursement.

- **Upgrading the core information technology (IT) system.** Funding for an initiative to replace parts of the SCVMC’s core IT system is not secure, putting at risk the potential to receive American Recovery and Reinvestment Act (ARRA) incentive money. The focus of this project is to work with management in determining an upgrade path that 1) is fundable, 2) maximizes the incentive money available through ARRA, and 3) improves user functionality.

- **Improving contracts and grant administration.** SCVHHS currently manages revenues and expenses that exceed $1 billion. Much of that is managed through contractual relationships, including contracts and agreements for goods and services related to patient care, professional services, construction, and IT, as well as agreements with managed care health plans. The goal of this initiative is to reorganize business processes and support capabilities to elevate contractual compliance in a manner that is more consistent with industry standards for a billion-dollar enterprise.

- **Maximizing charge capture and coding.** Clinical coding and documentation are critical to compliance and reimbursement. This project seeks to evaluate current coding and physician charge capture practices, identify improvement areas, and educate clinicians on improving their coding and charge capture practices.

- **Reducing clinical and administrative denials of claims.** Clinical and administrative denials due to inadequate clinical documentation and non-compliance with third-party payor payment rules are a potentially significant opportunity to enhance revenue. Improvement in this area requires data analysis to identify denial types and clinician education to correct documentation inadequacies.

This list of assignments provides an opportunity to make a vital observation about the system. Unless these solutions are planned and implemented with an eye toward the policy direction for the system—its North Star—we have fixed nothing for very long. There is no distinction, particularly in this environment, in solving a series of system problems unless the solutions are designed with the policy objective in mind. Will the solution advance our change process? Is the solution consistent with the expectations of our patients and practitioners? These are but two of the questions associated with these projects. Connecting all of these activities and processes into a coherent system view and strategy is something we refer to often and a discipline that must be embedded into the organization.

Another example surfaced while preparing this plan. We are all acutely aware of the difficult financial circumstances facing the County of Santa Clara and the State of California. Deficits for the state become shortfalls for the counties. Recently, the current SCVHHS was directed to develop plans to reduce its
operating budget by $15.6 million. Consequently, this document increases in importance. Without a set of guiding principles or objectives—or North Star—a budget reduction assignment becomes a compendium of political accommodations, silo attacks, or paper exercises driven primarily by the path of least resistance for the implementers. To return to an earlier analogy, rebalancing the portfolio is not only about making new investments but also protecting key assets.

Developing a unified managed care strategy and structure

As part of the strategic visioning process, the team met with the leaders of the two managed care plans associated with SCVHHS. The future of our system and the health status of the people we are responsible for depend utterly on our ability to manage and coordinate care. From any perspective this will be the definitive skill of the future. Any practitioner or system that cannot manage care well and efficiently will fail in the new environment. Although each of the plans performs well and provides valuable functions, executives of both plans acknowledged that there are many redundancies and duplicate costs—from disparate IT systems to separate physical offices and duplicate support staff.

To succeed in the current and future policy environment, the county will need to eliminate these redundancies and create a unified strategy and structure for managed care. The success of the system and the health status of those who depend on it will rest on the system’s ability to manage care in a streamlined, coordinated way. In the post-reform era, market agility, economy, transparency, service, and good outcomes will be among the measurements for recognition and payment. In developing the best approach and structure, several key questions must be considered:

• Does it make sense financially to continue operating two separate health plans?
• What investments are required to promote synergistic opportunities through a unified strategy?
• What are the costs and benefits of a unified approach to managed care in the county?
• How could health care delivery be improved through a unified approach (e.g., access improved outcomes, enhance provider and member satisfaction)?
• How does the unified approach to managed care support and enhance the strategic initiatives of the county and hospital system as they look to the future in the wake of health care reform?

The imperative is urgent to develop a single managed care structure that will leverage the lessons and experience of both current plans while strengthening the competitive position and community of the entire health care system.

“The Health System is ‘system centric.’ Consideration should be given to improving the interface and relationships between the county providers, other provider networks, hospitals, ancillary providers, and community-based organizations.”

- Greg Price, CEO, Valley Health Plan
- Pat Cox, Director of Clinical Services, Valley Health Plan
Aligning physicians

If the key to the future is integrated and managed care, noting candidly the opinions of the care leaders is an important step in designing the new system. How they conduct themselves and affect those around them will have much to do with the rate of change and success in the integrated environment. We interviewed 20 physician leaders at SCVHHS, covering a wide range of disciplines, departments, and roles within the system. As a whole, these physicians expressed a passion for their mission and for the patients they serve. Having been trained at some of the best medical schools in the country, many said that they had their choice of where to practice, but selected SCVHHS because of its mission, the opportunity to teach, and the quality and expertise of their colleagues.

Still, physicians expressed a high degree of frustration with the level of bureaucracy they encounter and limited ability to participate in major decisions affecting SCVHHS, although some thought that this was beginning to change. Key issues they cited include:

- **Lack of empowerment.** Many felt that they aren’t allowed to manage operations and budgets in their own department, a limitation that they believe reduces efficiency as well as their own accountability.

- **Lack of data and integrated IT.** Further compromising efficiency is the IT environment. The physicians noted that EMR implementation has been fragmented, and they don’t have the data they need for effective decision-making.

- **Compromised employee accountability.** Physicians cited numerous examples of how lack of accountability, at every level of the organization, decreases efficiency and compromises the organization’s ability to provide effective customer service. The organization, across the spectrum, must improve how it sets performance expectations by setting clear standards, coaching aggressively, and holding employees accountable for the quality of their service and impact on patients and customers.

Physicians had mixed views about the level of integration at SCVHHS. Many physicians, particularly department directors, indicated that they have a lot of interaction with colleagues, primarily clinicians, but also with staff from across the system. However, these interactions appear to be based primarily on personal relationships and initiative. Although some formal integration does occur, most acknowledged it is not at the level it needs to be.

Physicians also expressed apprehension about the level of customer service experienced in the system by the patients and their families. Noting that choice will be an aspect of reform, many of the interviewees were concerned that although SCVHHS has much to be proud of clinically, it also needs much to boast about from a customer service standpoint. Currently, its customer service ethic is modest. That is not helpful in the current atmosphere. In the new environment, it could be competitively lethal.
In planning for change, the critical first step for the health system is to develop a single, overarching vision statement. Although the agency and each department may have particular mission statements to guide their work, a unified vision statement has not yet been created that conveys what SCVHHS stands for—nor has a broad set of goals been developed to guide its future.

The new vision statement must be brief, memorable, and actionable. It must also resonate with the organization’s underlying ethics, history, and philosophy. Not only must it “connect” with SCVHHS staff and leaders, but it must be immediately understandable and inspiring to a variety of audiences. To brand and differentiate the health system in the market, to promote group cohesion, to bolster enterprise morale, and to communicate the right message to all who read it or hear it, the statement must serve as the North Star for the entire organization. Before this vision emerges, it must be preceded by a frank discussion of the current system drivers and themes.

In assessing where SCVHHS is today, an obvious and consistent conclusion surfaced quickly: the system is hospital-centric. SCVMC drives the structure, revenue strategy, and policy development of the entire organization. The system’s revenue, visibility, and influence radiate from the hospital and its attendant functions. Nothing could be more inconsistent with the policy direction and mandates of federal health care reform and the Medi-Cal Waiver. Moreover, the emerging literature about how best to address health disparities among the county’s low-income communities demands that the overall system become more integrated, prevention-oriented, and patient-centered.

Consequently, we believe that it is time to rebalance the portfolio of the health care system. To date, the system has invested in a strategy that will yield far fewer benefits in the future. If it takes an integrated, patient-centric, holistic approach to improving the county’s health status, the system will not only comport with the current policy environment but do more, over the long
term, for its patients and clients. Moreover, building on this approach, the system seeks to advance a philosophy of “health in all programs,” which asks all agencies and departments throughout the county—from Parks and Recreation to Planning and Development—to examine what role they may have in promoting a health agenda, of which the hospital and clinics are just one, albeit critical, component.

This rebalancing must be expressed in a vision statement that reflects the system’s ambition to succeed. Several options were extensively vetted with the strategic planning team and the physician leaders who were interviewed during this process.

Chart 2. New vision statement

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<td>Caring for you and the world around you</td>
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<td>• Promoting healthful living</td>
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<td>• Creating healthy and safe environments</td>
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<td>• Delivering high-quality care when you need it</td>
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We also reviewed with them three major goals that would drive the process of making the vision statement operational. From all of this material and discussion, we offer a new vision statement and set of goals (see Chart 2). In addition, we propose to rename SCVHHS “Valley Health” in order to convey a unified and integrated system whose mission is the health of the county. Hereinafter, we will refer to the system by the Valley Health name. Please note that, although the leadership team participants strongly supported this new vision statement, it has not been broadly vetted or subjected to market research—an important step before public dissemination.

Changing the culture, practice, and behavior of the organization to achieve these goals will not be easy. In fact, as challenging as the external pressures are, not to mention their uncertainty and fluidity, the greatest threats to the system are internal. Whether Valley Health can leverage the opportunities presented by PPACA will depend on overcoming four internal barriers to change (see Chart 3). Yet with a North Star now clearly visible, and three goals converging to guide the future, these challenges are indeed surmountable and an integrated system, achievable.

Chart 3. The four internal barriers to change

- Insufficient level of system integration
  - Lack of a unified strategy
  - Lack of prioritization and focus
- Cumbersome bureaucracy
  - Inability to change quickly
  - Health care politics
- Restrictive system culture
  - A reactive, episodic care—rather than holistic—approach
  - Inability to reward and/or discipline employees in a manner consistent with system goals
  - Inadequate alignment of the medical staff with system goals
- Lack of IT tools and integration
A roadmap for tomorrow

Understanding the five-driver model

To unify and integrate system activities at Valley Health, we begin with a model, or depiction, that is understandable and can be applied in the day-to-day work of the entire organization. Our starting point for integrating performance is the five-driver model. This model maintains that all organizations are powered by five drivers that recognize the inter-relationship between the organization of a system and the people who work in it. In summary, an organization’s strategy, tactics, and structure are developed and carried out by its people, whose behavior is highly influenced by the organization’s culture (see Chart 4). For an organization to succeed, all five drivers must be aligned and working—constantly and simultaneously—toward the organization’s goals, mission, and vision.

Chart 4. The five-driver model

We began this planning process by building a vision that will inform and drive the activities in the other categories essential to an integrated system. A strategy declaration without sufficient attention to the “enabling activities” becomes a shelf decoration. No matter how firmly we declare our intentions to become an integrated system, if we do not employ, retain, and promote the leaders and people who share that intention and have the skills to thrive in an integrated system, we are surrendering the long-term strategic direction of the system to the professional idiosyncrasies of individual practitioners, support staff, and the human resources system. If, at the same time, we make no definitive change in the system’s structure, the gravitational pull of the old structure will thwart any policy changes. For example, we use the term “rebalancing the portfolio” to reflect a new
direction. Unless the rebalancing is accompanied by a structural change that gives the public health activities and leaders greater authority in the new integrated system, any change will be superficial and brief. We also note as a result of our analysis and interviews that physicians must be given greater influence, authority, and administrative support in the new structure. Physician alignment is an indispensable ingredient to success in the new environment but it must be fostered by a different structure and set of incentives, or else it is a meaningless declaration of intent.

While each “box” is critical in and of itself, the connections between all five drivers are a vital—and often overlooked—part of becoming a high-performing enterprise. In fact, understanding and organizing activities outlined in the five-driver model is futile unless we simultaneously design efforts to work the space between the boxes. We refer to all of the activities that connect the drivers as “the interstitial space” (see Chart 5).

Mastering the interstitial space

In architecture, interstitial space refers to the space between floors in which one finds various systems and connectors that make the building or space do what it was designed to do. In organizations, it is the space that connects people.

Although this space is never overlooked in a construction project, it often is in organizational development. We assume that if we work on our floors, so to speak, somehow the connections will miraculously fuse to make a coherent, system-wide vision. It doesn’t happen like that. Ignoring the space between the boxes creates a vacuum into which contradictory policies or agendas wage war for resources and attention. Deliberately working that space, however, makes the various divisions, service lines, or groups come together. It helps them feel a part of achieving the broader goal of “what we are becoming.” Any organizational plan designed to succeed in the current health care environment must address, and master, how this space is managed.

It is also in the interstitial space that the true culture of the organization emerges. Culture is what people do when their leaders are not around. If the organization manages the space between the disciplines—and values the work there to the success of the enterprise—staff will grasp their role in that work and see the contribution of their daily activities.

Interstitial space is also what connects together the three major goals of Valley Health (see Chart 2). While most programs and services that the system operates exist predominantly within one of these goals, the interstitial space activities live between them. These activities serve to connect programs and services to ensure that they are aligned and work synergistically to achieve all goals. For example, a holistic approach to diabetes would coordinate efforts in the interstitial space between public health, primary care, mental health and substance use disorders, and specialty care to treat, manage, and prevent disease, thereby making progress toward all three goals identified as part of the new vision. Moreover, the drive to integrate care systems, whether it’s managed care, coordinated care, medical homes, or accountable care organizations (ACOs), presupposes the
capability of the system to connect all programs and activities for the benefit of the patient, member, or population. If you don’t manage the interstitial space properly, you can’t develop sustainable coordinated care or medical homes.

As another example, the electronic medical record is often seen as the key to achieving a more integrated health system. Yet the EMR does not in itself ensure system integration. It is, however, a key integration strategy that, when properly carried out, can promote integration by providing timely access to data across system disciplines.

The connection in interstitial space can be likened to a relay race. The extraordinary speed or endurance of the runner is assumed; that is essentially the work within each box. The success of the relay, however, depends on the success of the handoff—the connection between the runners; that is the work between the boxes. Teams practice the handoff relentlessly, because those transactions must be flawless. This is no different from the exacting quest to provide integrated or accountable care.

“Patient handoffs”—literally speaking, the transfer of patient responsibility from one health care professional to another, and figuratively speaking, a metaphor for all integrated system work—are the key determinants of success. Although these handoffs are acknowledged, they have rarely been the primary focus of organizational change or planning. Only the best systems, the ones we are hearing about more frequently as ACOs and integrated systems become the policy norm, practice the handoff. A full complement of health system workers—patient escorts, case managers, charge nurses, residents, attending physicians, appointment clerks, business office clerks, plant managers, HR employees, and IT specialists, for example—work part of their day in the interstitial space. Their ability to effectively master this space greatly impacts their individual success in their respective responsibilities and the collective success of a truly integrated system.

The trap into which most organizations fall is working furiously in each box yet ignoring the connective activity. In fact, to continue the relay race analogy, most health organizations that lose or fumble the handoff go back to the runners and tell them to go faster, start better, finish stronger. The interstitial space work is avoided often because it is harder, less glamorous, and less susceptible to the quick fix.

Not only must an organization acknowledge this space, it must design positions, activities, protocols, and training programs to master it. This is true for any organization to accomplish its integrative goals. But, when we consider planning for a change strategy—and it must incorporate the various departments and disciplines like public health, substance abuse, and mental health—it is the interstitial space that must be the primary focus of the effort.

When planning in a political subdivision like the County of Santa Clara or any other county, the merits of this focus grow. From a governance perspective, the interstitial space is the primary responsibility of the governing board. With rare exceptions, publicly elected governing board members are generalists, not subject matter experts. Thus their province is the ability to integrate and connect the various enterprises under their domain into a coherent picture of the value the County of Santa Clara government brings to its citizens each day. It is the board’s responsibility to see that these activities perform well together and relate to one another in a manner that allows each to fully realize its potential for high performance and extraordinary service. That is a particularly vexing problem when one is administering something as complex and dynamic as a health system. When we compound that by the extraordinary policy pressures on the current system, it argues for a permission to challenge the status quo of the current system in a way that would have been unimaginable just a short time ago. New ways to work, organize, pay, reward, assign, and lead are a few of the dynamics that will emerge as a result of the change in the health industry. What that means, particularly for the county structure, is unclear at this stage, but what is not in doubt is that many legacy activities and systems will no longer suffice in the new health environment.
Recommendations for change

The vision for the future health system is a high-quality, efficient, and fully integrated organization, united in serving the people of the County of Santa Clara in a holistic way through a comprehensive continuum of services and programs. The central philosophy of this system is to improve community health status by focusing on preventing disease and ensuring timely access to quality and appropriate health care when needed. The primary business strategy is to emphasize value and high standards, be nimble and responsive to market and community needs, and provide exceptional service. These dual imperatives are achieved when the system has clear accountability standards, is transparent, and is aligned under a single vision.

The recommendations provided here are intended to be guideposts for the system in achieving this vision. They are presented in four major categories, with specific activities listed under each.

**System integration**

Taking a system-wide view

The success of this strategic vision depends entirely on the ability of the new Valley Health to motivate staff, understand the environment, and integrate the system’s various activities. The integration effort must be intentional, consistent, and supported by all levels of the organization. Working this interstitial space, as we have referred to it, is the key to successful and enduring integration. Rhetorical support alone will be inadequate in confronting the circumstances challenging the health system; fostering integration requires deliberate focus and rigorous action. We would like to reiterate here our intent to rebalance the portfolio. This means that the system will need to alter its investment strategy so that prevention-oriented programs that have the greatest potential to improve community health are prioritized.

- **Create an Office of Program Integration.** The new office will serve as a clearinghouse to coordinate, manage, and be accountable for system-wide initiatives, and will be the repository for all integration design activities. This framework document can serve as an initial charter for the office.

- **Judiciously select leadership for the new office.** The formal office should be led by a dyad—a senior public health leader as well as a clinical service leader. Officially, and prominently, uniting the system’s public health and clinical services conveys a message consistent with the current policy environment. Both office leaders should report to the system leadership. The selection should be expedited. We recommend that one of the leaders be internal to the system and the other new to it.

- **Hold quarterly integration conferences.** Every 90 days for the next year, hold a formal integration conference for a minimum of four hours. The conference will reconvene participants from the managed care and system planning effort to assess progress, evaluate implementation, and recommend to the agency director any amendments to the program.

- **Designate a system integration executive for each major program element.** These executives, appointed by program leaders, will be accountable for integration activities in their respective areas. We recommend strongly that those serving on the planning committees be excluded from consideration. Permanent culture change requires that the leadership group committed to the new direction be constantly expanded.

- **Redirect implementation of the electronic medical record.** An effective EMR can promote a culture of integration. Data across disciplines becomes increasingly available. This engenders a respect for, and value of, what multi-disciplines bring to care. However, as stated earlier, an EMR itself is not integration. Simply automating a broken process does not fix it. Without effective implementation, organizational barriers and issues will continue to exist. The physician interviews made clear that EMR implementation efforts have not yet succeeded. At this point, by seeking input from current users, e.g., physicians, on the barriers and challenges within the current system, buy-in can be obtained and a unifying strategy created for effective implementation.

- **Create a culture of data-driven decision-making.** Data-driven decisions are essential for creating a system that practices evidence-based medicine and is aligned with a clear set of outcomes. The need for data in the changing health care environment has been repeatedly emphasized. Health care data must be linked with financial data to track individual and community health outcomes. In effect, the system must adopt an evidence-based management ethic.

“This plan represents a call to all of us—policy makers, county leaders, county staff, and community partners—to take bold and determined action for the health of our community.”

- Nancy Pena, Director, Mental Health Department, SCVHHS
Physician alignment  
Connecting the medical staff to the strategic process  

Physicians throughout the system—whether they practice in the inpatient, outpatient, mental health or substance abuse service settings—play a key role in the system’s strategy, clinical service delivery, and financial viability. Their leadership and capabilities have historically been integral to the system’s success. As important as those contributions have been, however, the current and future policy environment will require more system discipline and physician alignment. How much the system is paid, how it is compared to its competitors, and how successfully it prevents avoidable hospitalizations and unnecessary work will depend in large part on the leadership and commitment of its physicians. Achieving an integrated system will be impossible unless physicians are fully committed to its policies and purpose. Their commitment will depend on their level of connection to the system’s strategic direction and level of influence in decision-making.

• **Create a physicians’ council representative of all departments.** The council would formally fuse the medical staff to the strategic process and implementation of the integrated model. It would also update physicians on the strategic framework, as well as solicit physician input and insight into barriers and future direction.

• **Identify and bridge gaps in the physician organizational structure.** Designate integration and barrier removal specialists who can drive effective change. These specialists can bring substantive value, cost savings, and revenue for the system that more than cover the cost of their time away from direct care delivery. The medical center, for example, experienced the effectiveness of this type of effort when physicians led a one-day-stay reduction effort for the Department of Medicine. This initiative must also include an administrative support component. The increased expectations for the medical staff must be accompanied by an improved infrastructure that is tied explicitly to the initiation of evidence-based medicine and management system-wide.

• **Encourage formal meetings of physician leaders to consult on changes and policy expectations.** This effort can be tied to the Office of Program Integration and the every-90-day meetings referenced above.

• **Initiate a medical staff development plan (MSDP).** If physicians are a key element of success for the future Valley Health, a thorough analysis of the staff is essential. Matters of succession, physician satisfaction, leadership development, market demands, and treatment expectations of the system are but a handful of the elements of a comprehensive MSDP. This plan, and the unified managed care strategy described below, are two of the system’s major building blocks.

A culture of accountability  
Aligning employee performance to strategic direction  

A concern mentioned frequently in physician interviews and in the strategic planning sessions was the inability to effectively manage the workforce. Numerous examples were given of a lack of empowerment to counsel and, if needed, terminate incompetent employees. Participants and interviewees noted that no system was in place to reward and recognize exceptional performance. Numerous examples of excellence can be found in leaders and staff, but in general, no mechanisms are in place to recognize and promote this behavior throughout the organization. Many stated that the current structure, policies, and procedures promote mediocrity, not excellence. Creating a culture of accountability is a cornerstone of achieving the comprehensive change needed system-wide.

• **Obtain input from department leaders.** Gain consensus on the employee behaviors most in need of improvement, as well as behaviors that should be encouraged.

• **Benchmark against other organizations that have achieved the performance levels Valley Heath seeks.** Consider not only health care organizations, but leaders in other industries.

• **Develop processes and policies for employee management and recognition.** Work with the Employee Services Agency/labor relations to interpret performance guidelines and seek their support in making substantive changes to performance expectations. Strive for a balance in creating solutions—ensuring legal protection for the system, while maintaining flexibility for management to effectively manage.
• Engage union leadership. Ensure that the output of this effort includes union input and endorsement.

Managed care
Creating a unified managed care strategy and structure

The county’s current, dual managed care structure is an artifact from a different era in California health policy. The assumptions and dynamics have changed dramatically, and this old paradigm should no longer determine how managed care is delivered in the county. Although Valley Health Plan and Santa Clara Family Health Plan perform some unique functions, having two public health plans has also resulted in duplications and inefficiencies.

To succeed in the current and future policy environment, it is imperative that the County of Santa Clara develop a unified managed care strategy and structure that is agile and aligned with Valley Health’s new strategic vision. A large proportion of the uninsured who will gain coverage as a result of health care reform will do so through the Medi-Cal program, with payment methodologies moving toward risk-based structures. Moreover, the Section 1115 Waiver will result in the mandatory enrollment in managed care of seniors and people with disabilities (SPD) over the next two years. These policy initiatives present both an opportunity and a threat for Valley Health.

From an opportunity perspective, unifying the managed care plans and creating a single structure would strengthen the ability of the public plan to prepare for and compete in the expanded Medi-Cal managed care marketplace. A strong public plan is, in turn, critical for the future of Valley Health. With Valley Health’s comprehensive continuum of services and programs and new vision focusing on improving community health outcomes, a unified managed care structure has the potential to evolve from a managed care system to a managed health system.

A strong public plan would also provide a mechanism to better integrate Valley Health with the network of community providers needed to serve the expanding Medi-Cal population and enhance the ability to participate in the commercial market through the soon-to-be developed health insurance exchange. Since low-income people will likely shift between Medi-Cal and the exchange, as their incomes fluctuate, Medi-Cal managed care plans will need to be able to participate in the exchange. By integrating the expertise and experience of the two plans, a new structure can be created that ultimately aligns the data, customer service, management, and operation systems in a way that serves its members, supports Valley Health, and promotes the health of the residents of the County of Santa Clara.

However, if steps are not taken to integrate the plans, each plan will need to make new investments to meet the needs of the Waiver and PPACA. These investments will no doubt be duplicative, inefficient, and wasteful.

Therefore, it is strongly recommended that a short design and due diligence process be undertaken for the merger of Valley Health Plan and Santa Clara Family Health Plan. Focus should be on three primary areas: the status of the existing organizations (financial stability, capital needs, etc.); the infrastructure requirements to effectively drive the strategy; and the exploration of best practices that would best serve the county, support the system, and enable the system to effectively compete in the post-reform environment. Specific issues to be addressed include:

Current state
• Existing contracts review and the potential implications of a unified approach to those contracts
• Cost/benefit analysis in developing the unified approach
• Current market and/or payor population penetration
• Current redundancies

Infrastructure requirements
• Ability to track health outcomes for members and the population
• Service delivery model
• Capital investment needs
• Leadership and organizational staff requirements
• Framework to address increased financial and quality requirements
• Additional infrastructure requirements, such as information systems, internal hardwared services, and bandwidth
- Santa Clara Valley Medical Center and safety net support, including managed service organization–type services provided to the medical center

**Unified managed care structure or model**
- Governance and legal implications of the unified approach
- Governance structure, responsibility, and accountability
- Regulatory landscape—threats and opportunities
- Political/stakeholder assessment

Although input and assistance from executives and other representatives from the existing two plans are critical, we recommend that the review be completed by an independent party with no ties to either plan. Participants identified in this review must have the knowledge and skill to plan and develop the strategy based on the above criteria, and must be given enough time to complete the review in a timely way. While we recommend that the review be conducted by an independent party, there must be continuity among those who have been involved in developing the above recommendations in order to provide a clear understanding of the expected accomplishments and alignment with the vision. Members of the current unified managed care subcommittee would provide expert-level input and review. We recommend this process be finalized within 60 to 75 days after acceptance of the recommended unified approach.

**A vision in motion**

**Repositioning for the post-reform world**

Reinforcing to employees and the community the message that Valley Health is proactive, innovative, and integrated in its delivery of care is an essential element of this strategic framework.

- **Ensure that the strategic vision for Valley Health is well-known and embraced throughout the system.** The vision, as presented in this document, will help all system stakeholders understand the intent of the strategic framework and will support a system versus a silo view of the organization. Rather than a one-time communication blitz, the strategic vision should be a consistent, intentional, and ongoing message, used in each integration effort, so that every success, no matter how small, is tied to the larger strategy.

- **Invest in communicating integration successes externally through presentations, board meetings, and focused marketing strategies.** These strategies will be essential for enhancing the public’s perception of Valley Health’s quality and safety and improving the system’s competitive position in the post-reform world.

- **Develop methods for reporting clinical or operational accomplishments to the broader field.** Although the system has achieved many milestones, a mindset or culture to showcase these successes is lacking. Creating an interim function can serve as an initial step until a formal, centralized structure and process can be developed. One method to explore is identifying public speaking venues and writing opportunities in professional publications. Also, external contractors with expertise in interviewing subject matter experts and drafting articles can be consulted to accelerate the publication process.

- **Educate all stakeholders on integration strategies.** While all the above efforts will increase awareness of organizational changes, there must also be ongoing, sustained education throughout the system on the need for improved connectivity and the strategies in place to achieve it. A primary focus should be middle management, who are too often the “neglected middle.” This management group must understand the concepts of interstitial space, and be charged with promoting and creating better connectivity within their departments and across the system. If this targeted group “gets it” and buys in to the strategic efforts around improved connectivity, the strategy can be sustained over the long term.

“We have proven our ability to improve the health of patients; now the challenge is to improve the health of our whole community. Together, we can.”

- Amy Carta, Assistant Director, SCVHHS

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Valley Health: Caring for you and the world around you
What will be different?

All planning documents, whether designed to maintain or change the direction of the system, end the same. The intense staff work is accompanied by a bold statement of direction or purpose. Diagnosis of the organization—often designated by the SWOT acronym—leads to an outline of activities that will solve quickly the difficulties plaguing the organization. Sometimes the activities take the form of a revised structure, additional funding, a new partnership, or a fresh infusion of heroic leadership. These initiatives may help for a limited time, but do not sustain permanent, substantive change. We take a very different view.

Real sustained change is tedious, daily work that must be guided by a vision—North Star—that is distinctive, understandable, and actionable. All of the people in the organization must know what their organization is becoming and the part he or she will play in it. Those roles differ dramatically according to training, assignment, and experience. The only space of shared inhabitation is the interstitial space. How it is described and managed is the key to meaningful change in any organization, but it is the critical system skill when the policy environment demands and pays for coordinated, integrated care. To date, this “system” has been hospital centric—consolidated, but not integrated. The so-called interstitial space has been defined by years of hospital-dominated thinking, initiatives, reimbursement, and leadership. Change and sustainability depend entirely on the capacity of the new system to understand and integrate its various functions and direct its work away from episodic, acute care and toward the health of the community.

We noted earlier that we believe we have one chance to get this right. Market forces, economic conditions, environmental factors, and policy trends require a new, sustainable health system. This work must begin with a frank and universal concession that what has gotten us to this point—hospital-centric thinking—cannot get us to the next iteration of SCVHHS, Valley Health.